Emergency Care System Still at the Breaking Point

by Kathleen Ream, Director of Government Affairs

One year after a report issued by the Institute of Medicine (IOM) concluded the nation's emergency care system was "at the breaking point," the House of Representatives Oversight and Government Reform Committee heard testimony on June 22, 2007, regarding emergency care in the United States. With America's emergency departments operating at or over capacity, the nation's healthcare safety net, the quality of patient care and the ability of ED personnel to respond to a public health disaster are in severe peril.

Three emergency physicians from rural, suburban and urban areas testified that some hospitals do not have enough beds to admit patients, forcing an ED backup or diverting ambulances to other EDs. Additionally, the shortage of healthcare professionals – particularly surgeons to provide emergency and trauma care – was highlighted as one aspect of the overall problem.

Reimbursement for emergency care services was also noted as an issue within the current crisis. Dr. William Schwab from the University of Pennsylvania recommended that Congress direct the Centers for Medicare and Medicaid (CMS) and third-party payers to reexamine the funding for emergency care. Dr. Robert O'Conner from the University of Virginia testified about the lack of funding support for emergency care at the federal level. He noted that the majority of funding for emergency care comes from CMS in the form of low reimbursement rates for emergency care and stated that the lack of federal support prevents emergency departments from preparing for a public health disaster.

Officials from the Department of Health and Human Services (HHS) testified that the Department was undertaking changes, including looking into creating a lead agency on emergency care, using assistance from the Health Resources and Services Administration, from CMS to promote regionalized approaches, and using the Food and Drug Administration, National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) to promote emergency care research. All of the emergency physicians at the hearing complained that the lack of a lead agency exacerbates the current situation. Dr. Walter Koroshetz, Deputy Director of the National Institute of Neurological Diseases and Stroke at NIH, testified that future emergency care research is at risk.

Representative Elijah Cummings (D-MD), who chaired the hearing, said that HHS "appears to be ignoring the mounting emergency care crisis," despite the billions of dollars spent on biodefense and flu pandemic preparedness. Cummings added that HHS has "not made a serious effort to identify the scope of the problem and which communities are most affected." The emergency physicians stated they had seen no money come their way as the billions of dollars in additional funding went to other first responder related needs. Dr. William Schwab and Dr. Johnson from Mission Hospital Regional Medical Center stated that raising salaries for emergency physicians, along with malpractice relief for emergency practitioners, would boost ED staffs. While adopting crisis measures to increase emergency department capacity may provide a short-term solution to a surge of patients, all of the witnesses testified that ultimately the country needs long-term answers.

For more information on the IOM's 2006 report ***The Future of Emergency Care,*** go to the IOM's website at http://www.iom.edu/CMS/3809/16107.aspx. For electronic copies of the testimony from the June 22nd hearing, please visit http://oversight.house.gov/story.asp?ID=1363.

Infection Tracking System Available to U.S. Hospitals

The CDC recently announced that a secure, web-based reporting network that enables the tracking of infections is now available to all healthcare facilities in the United States. The National Healthcare Safety Network (NHSN) provides multiple options for data analysis and more flexibility for sharing information both within and outside a facility – including the general public, if the facility so chooses.

"Opening this system to all hospitals is a milestone for health protection," said Denise Cardo, director of CDC's Division of Health Care and Quality Promotion. "Information is power, and the information tools that NHSN provides help healthcare facilities prevent healthcare-associated infections, including methicillin-resistant staph infections (MRSA)."

The NHSN system builds upon the CDC's National Nosocomial Infection Surveillance system, which, for more than 30 years, was the gold standard for tracking healthcare-associated infections. Cardo said, "We expect nearly 1,000 facilities will take advantage, in coming months, of NHSN's many capabilities."

To date NHSN has more than 600 participants and is used in 45 states. The CDC is already partnering with dozens of healthcare facilities, including the Department of Veterans Affairs hospitals, to use NHSN as a tool to track the prevention of MRSA infections. In addition, NHSN now meets the needs of states with mandatory public reporting of healthcare-associated infections.

For more information on NHSN, go to http://www.cdc.gov/ncidod/dhqp/nhsn.html.

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Another EMTALA Case Swings on "Appropriate" MSE

On April 4, 2007, the U.S. District Court for the Western District of Louisiana decided that the Emergency Medical Treatment and Labor Act (EMTALA) was not violated by a Louisiana hospital that had discharged a minor complaining of severe abdominal pain, and who later was returned to the hospital for emergency surgery of a ruptured appendix (Spillman v. Southwest Louisiana Hospital Association, W.D. La., No. 2:05 CV 450, 4/4/07).

The Facts

Joyce Spillman brought her son Brandon Dicks, who was suffering from right lower quadrant abdominal pain, to the ED at Lake Charles Memorial Hospital (LCMH). Absent running tests on Dicks, the ED physician diagnosed "acute gastritis," prescribed medication for nausea, and discharged the young man.

Dicks continued to experience pain, so upon advice of Dicks' pediatrician, Spillman took her son to the ED of a second hospital. At this hospital the ED physician ordered a CT, but it is unclear as to whether the ED doctor was notified of the results. Dicks again was prescribed medicine for the pain and sent home.

The pain never ceased, so Spillman had the family physician assess the earlier CT scan report, only to determine that Dicks' appendix had ruptured. Dicks then was admitted to LCMH for emergency surgery. Shortly thereafter, Spillman filed an EMTALA suit on behalf of Dicks against LCMH. The defendant sought summary judgment.

The Ruling

A defendant is entitled to summary judgment when the defendant can establish that there are no genuine issues of material fact for trial. A "material" fact is one that might affect the outcome of the suit under the applicable substantive law; and in order for a dispute to be "genuine" the evidence before the court must be such that a reasonable jury could return a verdict for the nonmoving party.

Plaintiff Spillman contended that because CSPH's examination of Dicks fell below the applicable standard of care, CSPH failed to provide an EMTALA appropriate medical screening examination. The court reasoned that EMTALA was enacted to prevent patient-dumping, not to be used as a federal malpractice statute. "A hospital's liability under EMTALA," wrote the court, "is not based on whether the physician misdiagnosed the medical condition or failed to adhere to the appropriate standard of care. Instead, the plaintiff must show that the hospital treated him differently from other patients with similar symptoms."

The court found that there was no evidence that the defendant normally treated patients with abdominal pain any differently than it treated Dicks. And, too, the court was unable to find any precedent to support the theory that a presumptive diagnosis [of appendicitis] triggers a hospital's duty to stabilize or transport under EMTALA.

The court concluded that "[a]lthough the plaintiff may have a cognizable and possibly successful claim for medical malpractice, there is insufficient evidence to create an issue of material fact regarding the EMTALA claim." The hospital was granted summary judgment.

The decision can be read in full at http://op.bna.com/hl.nsf/r?Open=sfak-724rzy.

AAEM's Government Relations Resources

Advocacy is more than just understanding the issues. To make a difference, you have to make your voice heard. The involvement of individual emergency medicine physicians is vital to the success of AAEM's grassroots efforts. To assist you in your government relations activities, AAEM provides the following services and information:

AAEM E-Mail Alerts

AAEM E-Mail Alerts provide strategic information to affect key policy issues of concern to emergency medicine. To receive future alerts, sign onto the Action E-List on the homepage of the Legislative Action Center, http://capwiz.com/aaem/home.

Legislative Action Center

The Legislative Action Center, located on AAEM's website, www.aaem.org, is "one-stop" shopping for federal legislative and regulatory information. It contains the important issues that AAEM is tracking for you, recent votes, current bills and other relevant items. You can search the congressional database by name, state, committee or leadership, and send messages to your congressional delegation directly from the site.

Additional features include:

- "Sponsor Track" which attaches information on relevant bill sponsorship on Members' bio pages;
- A "Vote Scorecard" listing every Member of Congress and how they voted on bills of interest to AAEM;
- "Megavote" provides you with a weekly e-mail on the voting patterns of your Representative and Senators;
- A searchable "Guide on National and Local Media" including newspapers, magazines, TV networks and stations; users can send e-mails, faxes or printed letters to newspaper journalists, radio talk show hosts and television commentators; and
- Detailed "Campaign Contribution Data."

Washington Sentinel

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